NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Office of Mental Health, Substance Abuse and Addiction Services
P.O. Box 98925
Lincoln NE 68509-8925
(402) 479-5574

APPLICATION FOR CERTIFICATION AS A CERTIFIED COMPULSIVE GAMBLING COUNSELOR (CCGC)

(Type Application)

SECTION A – GENERAL INFORMATION

1. Name: _____ _____ _____
(Last) (First) (Middle)

_____ _____
(Maiden) (Other Last Names Records May Be Under)

2. Home Address: _____
(Street / P.O. Box / Route)

_____
(City) (State) (Zip)

_____
(County)

3. Home Telephone No.: (____) _____

4. Social Security No.: ____ - ____ - ____

5. Date of Birth: _____
Mo. Day Yr.

6. Male: _____ Female: _____

7. Race / Ethnicity: (Optional; for statistical purposes only)

[ ] American Indian
[ ] Asian / Pacific Islander
[ ] Black / African American
[ ] Hispanic Origin
[ ] White / Caucasian
[ ] Other _____

8. Current Employer: _____
(Agency)

_____
(Program / Department / Division)

9. Work Address: _____
(Street / P.O. Box / Route)

_____
(City) (State) (Zip)

10. Work Telephone No.: (_____) _____

11. Do you request special consideration in test administration because of a disability?
_____No _____Yes. If yes, provide official documentation of the disability and specific procedure changes sought.

12. Are you certified / licensed as a compulsive gambling counselor, either nationally or in any other state?

_____No _____Yes If yes, complete:

State Certified In (if applicable):_____

Certifying Entity: _____

Address: _____

Telephone No.: (_____)_____

Your Certification Title: _____

13. Has disciplinary action ever been taken on your license / certificate?
_____No _____Yes If yes, complete:

Date of Action: _____

Type of Action: _____

14. Have you ever been convicted of a misdemeanor or a felony?

_____No _____Yes If yes, complete:

Crime Committed: _____

Date of Conviction: _____

Location of Court: _____
(City) (County) (State)

(Attach official court documents regarding circumstances of charges, disposition of the case, whether probation / parole has been completed [if applicable] and your current legal standing.)

SECTION B – EDUCATION

Applicants must document high school completion. Attach copy of high school diploma / transcript or GED certificate. Submit official transcript(s) for other education listed.

1. Check highest level completed:

[ ] High School Diploma or GED
[ ] Some college
[ ] College Degree – Associate
[ ] College Degree – Bachelor
[ ] College Degree – Master
[ ] College Degree – Doctorate

HIGH SCHOOL / GED

2. High School Graduate? _____No _____Yes If yes, complete:

School Name: _____

School Location: _____
(City) (State)

Date of Graduation: _____
(Month, Year)

3. GED Completed? _____ N / A _____No _____Yes If yes, complete:

Date Issued: _____

Issued by: _____

_____
(City) (State)_

UNIVERSITY AND COLLEGE (Undergraduate, Graduate, Doctorate)

Please complete the following information on any post secondary education completed by the applicant.

4. Name & Location From To Total Hrs. Field of Study Degree Earned

Name	**Mo./Yr.**	**Mo./Yr.**		**Major**	**Mo./Yr.**
Location				**Minor**	**Degree**
Name	**Mo./Yr.**	**Mo./Yr.**		**Major**	**Mo./Yr**
Location				**Minor**	**Degree**
Name	**Mo./Yr**	**Mo./Yr**		**Major**	**Mo/Yr**
Location				**Minor**	**Degree**
Name	**Mo/Yr**	**Mo./Yr**		**Major**	**Mo/Yr**
Location				**Minor**	**Degree**

SPECIFIC EDUCATION CONTENT AREAS

Applicants must document (72) hours of education related to the knowledge and skills of compulsive gambling counseling. List the education you are submitting for each area. Verification of completion must be provided for all education listed. Enclose content information on education submitted that is not pre-approved by the Office of Mental Health, Substance Abuse & Addiction Services as meeting a content area.

5. Basic Compulsive Gambling Knowledge (12 hours minimum)

Course Number and Title	Dates Attended	Training Provider	Approval #	Hours Earned

6. Intake and Assessment of Compulsive Gambling Clients (12 hours minimum)

Course Number and Title	Dates Attended	Training Provider	Approval #	Hours Earned

7. Significant Other Treatment of Compulsive Gambling (12 hours minimum)

Course Number and Title	Dates Attended	Training Provider	Approval #	Hours Earned

8. Case Management for Compulsive Gambling Clients (12 hours minimum)

Course Number and Title	Dates Attended	Training Provider	Approval #	Hours Earned

9. Individual and Group Counseling Skills with Compulsive Gamblers (12 hours minimum)

Course Number and Title	Dates Attended	Training Provider	Approval #	Hours Earned

10. Special Population Issues for Compulsive Gambling Counseling (6 hours minimum)

Course Number and Title	Dates Attended	Training Provider	Approval #	Hours Earned

11. Legal/Financial Aspects of Compulsive Gambling (6 hours minimum)

Course Number and Title	Dates Attended	Training Provider	Approval #	Hours Earned

PRACTICUM – SECTION C

Applicants must document 200 clock hours of practicum experience with a minimum of 20 hours supervision from a Office of Mental Health, Substance Abuse & Addiction Services approved supervisor. The practicum must document the following minimum hours performed in each performance domain:

1. A minimum of forty (40) hours in the area of intake and assessment.
2. A minimum of forty (40) hours in the area of case management.
3. A minimum of eighty (80) hours in the area of counseling.
4. A minimum of twenty (20) hours in the area of client, family, and community education.
5. A minimum of twenty (20) hours in the area of professional responsibility.

Practicum hours must be documented on the "Verification and evaluation of Practicum" form and included with the application.

*** If substituting national certification, indicate below:**

☐ **Holds valid national certification (attach copy of certification)**

Practicum Site

Please complete the information below for your practicum site(s).

1. Type of Practicum: [ ] Formal Post-Secondary Educational Program
   [ ] Part of Work Experience (on-the-job)
   [ ] Volunteer

2. Dates of Practicum: _____ To _____
   (month / year) (month / year)

3. Agency Where Practicum Occurred: _____

4. Agency Program / Department / Division : _____

5. Address: _____
   (Street / P.O. Box / Route) (City) (State) (Zip)

Attach "Practicum Verification" form.

Reference – Section D

One reference must be received from a current or previous compulsive gambling practicum supervisor. List the individual to whom you gave the "Verification and Evaluation" form.

Practicum Supervisor Evaluation

Name: _____ Phone: (_____) _____

Agency: _____

Work Address: _____
(Street / P.O. Box)

_____
(City) (State) (Zip)

Code of Ethics – Section E

Applicants must agree to subscribe and adhere to the following Code of Ethics:

1. Provide and support the highest quality of care in the recovery of all persons served which shall include referring, or releasing an individual to other health professionals or services, if that is in the individuals best interest.

2. Respect the unique characteristics of the professional counseling relationship which demands sound, non-exploitive inter-personal transactions between client and counselor.

3. Respect the therapeutic needs of the client by not engaging in a personal or sexual relationship with the client.

4. Respect the therapeutic needs of the client by not conducting any business or political transactions with the client, that may jeopardize their therapeutic needs.

5. Adhere to a strict policy of non-discrimination in the provision of services by not discriminating based on; race, disability, appearance, religion, age, sex, intelligence, sexual orientation, national origin, marital, economic, educational, or social status.

6. Respect the basic human rights of all clients including; their right to make their own decisions, to participate in any plans made in their interests, and to reject services unless a court order stipulates otherwise.

7. Adhere to the legal requirements for confidentiality of all records, materials, and communications, regarding clients, their families and significant others.

8. Assess their personal and professional strengths and limitations, biases and effectiveness on a continuing basis. Strive for self-improvement, and assume responsibility for professional growth through further education and training.

9. Respect the rights and views of fellow colleagues and members of other professions.

10. Refrain from the abuse of mood altering chemicals or gambling, in a manner that will reflect adversely on the credibility and integrity of the profession.

11. Report evidence of incompetent, unethical, unprofessional, or illegal practice of a certified compulsive gambling counselor.

I have read and agree to be bound by this Code of Ethics.

Signature of Applicant _____ Date _____

Affidavit - Section F

Applicants must complete this section of the application before a Notary Public.

STATE OF _____)
) SS
COUNTY OF_____)

I, _____,
(Applicant Legal Name)

being duly sworn say that I am the person referred to in this application.

I hereby certify that all the information given herein is true and complete. I authorize any relevant investigations or the release of personal information to the Department of Health and Human Services, Office of Mental Health, Substance Abuse and Addiction Services, or its agents, pursuant to this application procedure. I understand that falsification of any portion of this application will result in my being denied certification, or revocation of same, upon discovery.

I further agree to hold the Department of Health and Human Services, Office of Mental Health, Substance Abuse and Addiction Services, its agents, employees, Certification Advisory Board members and examiners free from any civil liability for damages or complaints by reason of any action that is within the scope of the performance of their duties which may be taken in connection with the application and subsequent examinations and/or the failure of the Office of Mental Health, Substance Abuse & Addiction Services to issue certification.

_____
(Legal Signature of Applicant)

Sworn before me this_____ day of _____, _____.

_____
Notary Public

My Commission Expires: _____

(SEAL)

ENCLOSE $150.00 certification fee. Make check or money order payable to "Department of Health and Human Services."

DO NOT SEND CASH.

SUBMIT APPLICATION AND FEE TO:

Department of Health and Human Services
Office of Mental Health, Substance Abuse and Addiction Services
ATT: CCGC Certification
P.O. Box 98925
Lincoln, NE 68509-8925